Reflections on Contemporary Psychiatry

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• **Valid data on the effectiveness of preventive programs in psychiatry are badly needed but cannot be obtained until reliable statistics on incidence and frequency of emotional disorders are available.**

There is a suggestion that clear cut neuroses are less frequent but an equally strong suggestion that psychosomatic disorders are increasing in frequency. There is a tendency to look upon the increasing freedom of some aspects of our culture as a great advance over Victorian rigidity and restraint—but to what extent is this related to seeming increases in delinquency?

Parents seem to have become increasingly fearful of disciplining, training or frustrating children as a result of what is considered psychiatric teaching. Psychiatry has the responsibility for correcting such a misunderstanding. Psychotherapists who have not resolved their own dependency needs are in no position to help others with the dependency problems which underlie their neurotic difficulties. Psychotherapy involves more than just arranging the world to accommodate itself to the patient (which occasionally needs to be done). The patient too, has a responsibility for his illness and its treatment and must learn that life is characterized by the need to take some chances, by dangers, difficulties, frustrations and unknowns, as well as pleasures, safety, comfort and the familiar. The responsibility for meeting the need for psychiatric services belongs to all of medicine and not just to psychiatry.

A LITTLE REFLECTION on psychiatry as it is practiced today points up the need to examine some of the basic concepts and practices and, if possible, their effects. We use terms like "mental health" and "reality," but can we really adequately define them? When we refer to mental health, are we using it in a social sense (referring primarily to the individual's relations with society and the interrelations between different societies) or in a medical framework (referring primarily to how the individual feels and functions), or both? Are we thinking of the degree of psychopathologic change that is present or the degree of disability, or both?

We have learned that these are two different things. A person may have a great deal of psychopathologic disturbance but be only slightly disabled. Furthermore, the degree of disability in a given person varies greatly from time to time in response to external dangers and changing motivations.

The ability to get along with others with a reasonable degree of happiness and satisfaction and productivity is generally considered the criterion of mental health. This at least is an important aspect of the goal of psychotherapy, which attempts to help patients see reality so that they may adjust to it more satisfactorily. One difficulty is that reality has a way of changing, sometimes quite suddenly. Mental health, more obviously than physical health, is intimately bound up with motivations. Can we say that mental health, like physical health, is concerned with an increased ability to survive? If it is, does it encompass being willing to risk one's life for a cause when the chance of survival is known to be nil, but when it seems apparent that someone has to make the sacrifice? Or does mental health imply the ability to get along in any culture without faltering, a relative acceptance of what is? Or does it entail the willingness to fight even when it might be very unhealthy to do so? Such philosophical considerations are ordinarily burdensome, but the time may come when we shall have to answer such questions, and the chances are that opinions will differ greatly on what mental health is.

Perhaps it would be easier to consider the problem from another direction, that of mental illness. We talk of prevention of mental illness, but then when we try to measure it, we have no truly reliable baseline of overall incidence to start from (as can be done with typhoid or diphtheria). With all of the psychotherapy being practiced, with all of our guidance clinics and mental hygiene programs, have we ever decreased the incidence of mental illness? Have any of the programs which we so hopefully depend upon had any preventive effect? We know from our experience that we are helping some people and that as our knowledge and skill and numbers increase, more and more are being helped, but we are in the position of carefully nurturing and weeding a small garden that is surrounded by miles of weeds and underbrush that spreads many times faster than any enlargement we make in the garden.

There are many good indications of the magnitude of the problem of emotional health: The number of men and women who were rejected for military service for emotional disorders; the number of men and women who are receiving compensation from the federal government for emotional disorders; the increasing number of patients in state hospitals; the incidence of crime and suicide;

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studies of communities such as were done by Lemkau[1] in Baltimore and Mangus[2] in Ohio.

There is need, however, to establish firm and reliable incidence and frequency baselines. These, in turn, depend on the establishment of firm criteria, which in turn, depend on the definition of mental health or, rather, ill health, which in itself is complicated because, like the common cold, it is something that practically everyone has at different times and to varying degrees.

It is disturbing to consider the possibility that, despite all our efforts directed toward helping individuals and toward developing community programs, the incidence of emotional disorders may be increasing (certainly we have no indication that it is decreasing). There is a suggestion that clear-cut neuroses such as used to be seen are less frequent, perhaps because their meaning has been exposed; but there is an equally strong suggestion that psychosomatic disorders are increasing. Like the criminal who goes into hiding when in danger of being detected, conflicts and unacceptable feelings and impulses may go more deeply underground and evidence themselves by disturbed bodily function which is even more difficult to treat. This in no way implies that we should abandon our treatment of individuals in private offices or clinics, but it does mean that we cannot continue to bank on these efforts as the ultimate solution to the problem and enjoy the feeling of making real progress until we can prove, in ways that are more convincing than the ways we have at present, that we are making a significant contribution to the overall health of the nation. Medical colleagues, who are skeptical about some aspects of psychiatry and its methods, constantly ask for proof that its contentions are true. Will psychiatrists be like the medical scientist who discovers the cause of typhoid fever and then goes on to develop a preventive program that practically eliminates the disease, or will they be like the astronomer who by careful observation establishes sound hypotheses which permit him to predict accurately but provide no means of changing the events he predicts.

There is always in most persons an undercurrent of dissatisfaction which has deep roots in our personalities which prompts us to improve things, to improve our lives, our comfort, our safety and the world for our children. Do we have a tendency to look at only one side of the coin, to consider what we are buying and not the cost? What price have we paid for the radical change in our culture and standard of living over the past one hundred years?

Is the universal longing for the good old days (of the past) merely the manifestation of the desire to return to the womb, or the breast, or the bottle, or is it in part a recognition that with an increase in the good, there is an increase in the bad or undesirable, the part that only the spoil-sport calls attention to? Perhaps it is not fair to recall the fate of past cultures like those of Rome and Greece that had it so good. In their time, it seemed that progress almost beyond imagination was being made in human welfare.

We tend to look back a little smugly, and sometimes critically, on the rigidity and repressive character of the Victorian Era. We can point with some pride to the decrease in conversion reactions that seemed to accompany a freer attitude toward sex and anger (a development that is certainly attributed, correctly or not, to psychiatry). A comparison of the incidence of hysteria in World War I and World War II is quite dramatic and it is doubtful that the difference is just a semantic one. What, however, has occurred to the incidence of "acting out?" Is there any relationship between the increasing problem of delinquency and our greater freedom? Or is this related, as some observers would suggest, to the changing role of women (and men) in our culture, which again is heralded by claims of great progress? Or is it, as some sociologists would claim, that there is no increase in delinquency, but that the criteria for delinquency have changed in a society that tolerates less and less misbehavior in its young.

It is of interest that with a relatively low birth rate, there is an increased concentration on the welfare and needs of the fewer children. While on the one hand this seems to be desirable and good for the children, in that their needs are satisfied, it can also promote an increase in the children's expectations that their needs will continue to be satisfied by the big world as it was done earlier in the little world of their families, while at the same time more may be demanded of them in the way of social conformity. It is difficult to know where all this ends, but many seem to believe that in our culture there is a progressive increase of an attitude of "who is going to take care of me?" or of an expectation that it is "someone's (usually the government, which means everyone else) responsibility to take care of me," together with increasing resentment regarding the restrictions and relative impotence that accompany a dependent relationship. This is somewhat related to another problem.

One frequently hears complaints that schools are too permissive, that not enough is being demanded of children, that training or self-discipline, for themselves, are bad. Parents seem to be increasingly fearful of frustrating children, of disciplining them, of training them, of disappointing them, and even of depriving them of the freedom of witnessing their intimate activities in bedroom and bathroom. Strangely, psychiatry is used as the authority.

It becomes the responsibility of psychiatrists to look to our practices to see if we are responsible; and, if we are not, should we be doing something to correct so serious a misunderstanding?

Forel, the famous Swiss psychiatrist, was struggling with the problem of the alcoholic. He was brought up when the prevailing attitude was that if alcoholics were deprived of alcohol, it would lead them to death or suicide. In other words, it was looked upon as a need that had to be satisfied. Such was the traditional logic of those days. In 1884, Dr. Forel, upon learning that his shoemaker was a total abstainer and the chairman of a temperance society, made arrangements to send every alcoholic in his hospital to the shoemaker, with an attendant, and to meetings of the society. For the first time in his life, Forel said, he saw drunkards recover, truly and lastingly cured. Thereafter the part played by Dr. Forel in the treatment of the patients was less and less, and finally the psychiatrist asked the shoemaker to explain. The shoemaker replied: "It is very simple. I am an abstainer and you are not. This is the secret. You cannot teach others convincingly that which you do not do yourself." (This is truly remindful of Alcoholics Anonymous of today.)

Psychiatrists consistently see exaggerated dependent needs underlying neurotic difficulties (the term here used in a broad sense). Perhaps it is traditional logic, today, that such needs must be gratified; and perhaps only when psychotherapists who deal with neurotic dependency problems have, through self-understanding, resolved their own dependency needs, will they be able to teach their patients convincingly.

One hears a great deal of talk about mothers rejecting their children, of advice to mothers to love their children. How can someone produce love on demand? It is as if to say that unless the mother is amiable, undisturbed and understanding, unless she is thinking only of her child and its comfort, she is "rejecting" is not "loving." This kind of propaganda (which seems to stem from the proponents' identification with the so-called rejected children and their own needs for the "wonderful mother") carries with it the danger of aggravating mothers' anxieties and impairing what healthy instinctive behavior they might manifest over and above their neurotic behavior. Blaming Mother is an easy way to explain an individual's emotional difficulties. But why was Mother the way she was?

Mobilizing hatred for parents is not enough, and should not be the goal of treatment. Rather it should be understanding others' needs and problems (including those of parents) as well as one's own. Often the anxious mothers (and fathers) identify with their children and attempt to provide the cotton wool environment for them that they themselves continue to seek in a neurotic way. When they are encouraged in this by professional advisors, the problem in the long run can only be aggravated. The child is not helped in his struggle to face and cope with life. The world is not going to treat him in the same overprotected way. All mothers love their children, except those who are very sick and probably psychotic. Their love may be colored, distorted and adulterated by their neurotic difficulties, but that does not mean they do not love their children. They may be unrealistic, torn by conflicting feelings, frustrated, bitter, unhappy, and their feelings may "muddy the water." To indiscriminately attribute a patient's continued oral cravings just to a mother's rejection is to deny one of Freud's great discoveries, that of conflict and regression. It as often may be a defense against sexual and other fears, an attempt to solve conflicting childhood sexual desires, as it is what it appears to be on the surface.

It is a strange thing, but parents may have to punish children, frustrate them for their own good—and when someone does something for another's good, it is a manifestation of love. Treating a child as if it could not stand any pain or frustration is not loving the child, but loving one's self. Even sibling rivalry which develops in the child somehow gets blamed on Mother. The hatred which the child develops toward a younger or older sibling may be rationalized by all kinds of memories of preferred treatment (and sometimes this has really been the case), but basically the "rivalry" often is the black-or-white, all-or-none attitude expressive of an insatiable wish for all the attention.

An extension of this practice is to blame mental illness on the government, or on conditions, or to emphasize cultural forces (many of which undoubtedly exist)—to emphasize, indeed, anything except the role the individual is playing in his or her own difficulty. Particularly during the war, psychiatry was accused of permitting the weak to hide behind the skirts of psychiatry, of being too protective and of mollycoddling. There are many possible reasons for this. Psychiatrists were bold enough to insist that people might be incapacitated by emotional difficulties short of psychosis. This was something that everyone knew—but it was felt that emotional difficulties should be considered a weakness, a failure of responsibility, a preoccupation with one's own needs and feelings to an exaggerated degree, and, therefore, something to be treated with contempt, ridicule and even punishment. It was felt by many persons, and perhaps especially by those who were struggling with their own emotions—"but not giving in"—that if the psychiatric patient was treated with sympathetic understanding, it would encourage a lot of others to seek the same kind of treatment.

The psychoneurotic was looked upon as a coward who gave in to his fears; and since in wartime a

great many people were afraid, it was feared that a sympathetic approach to those who could not cope with their fears would create an avalanche of psychiatric disorders that would decimate the ranks of the army. Unfortunately, there were a few psychiatrists who, perhaps through lack of understanding, assumed purely protective roles and considered environmental manipulation the only possible approach. To some extent this probably exists in civilian life, and apparently we psychiatrists have not yet convinced our colleagues in medicine that it is possible to be understanding and sympathetic but not protective; that psychotherapy involves more than just arranging the world to accommodate itself to the patient (which occasionally needs to be done); that the patient, too, has a responsibility for his illness and its treatment, and that life is characterized by the need to take some chances, by dangers, difficulties, frustrations and unknowns, as well as pleasures, safety, comfort and the familiar.

The patients of psychiatrists learn this, but somehow these concepts have not yet been transmitted to medical colleagues who still suspect that in the privacy of psychiatrists' offices patients are encouraged to act out their suppressed desires without regard for convention or mores.

Medical colleagues still manifest their natural resistances to accepting psychiatric concepts and there exists a tremendous need for education in this area. We continue to witness the separation of psyche and soma and we are just beginning to show in a convincing way that illness is multi-determined and not just something that can be explained by roentgenography and bacteriology. Intensive work with individual patients has taught us much, but it has tended in some instances to isolate psychiatrists from the rest of medicine. This, plus the public's traditional concept of the physician as one who deals with physical illness, medicines and operating rooms, contributes to the confusion in the public's mind about what kind of physician a psychiatrist is. It is not very clear, in the public's mind, how he differs from the psychologist who, to a greater extent than the physician-psychiatrist, has become identified with child guidance. The unique training of the psychiatrist in both organic and psychogenic disorders gives him a special competence gained in many instances through great personal sacrifice. It is gratifying to see how many have been eagerly awaiting the opportunity to pass on their experience to students of medicine and psychology and other allied professions. The need for their services will surely increase as time goes on. There appears to be little prospect of the psychiatric specialist's even coming close to meeting the tremendous demands from hospitals, clinics, correction institutions and industry. This would seem to be the responsibility of all of medicine and not just psychiatry. Basic training in the fundamentals of psychiatry and psychotherapy must be included in the undergraduate medical curriculum so that all physicians will have some competence to deal with the infinite number of emotional and behavioral problems for which they are consulted. The physician with special training in psychiatry will continue to lead the way through basic and clinical research coordinated with internists, dermatologists, pediatricians and oncologists, assisted and in many instances guided by other members of the psychiatric team which is gradually expanding to include the social scientist. Maybe psychiatry is not too far away from the controlled studies, based on valid designs, that have been demanded of it for so long. Maybe psychiatry can come to grips with the problem of the continually increasing numbers of patients in state hospitals even though many highly trained psychiatrists show little interest in this sickest group of patients, often avoiding getting involved with such patients and many times not even being familiar with the technique of commitment.

We must do what we can to discourage the building of state hospitals in remote areas. Their continued isolation symbolizes the wish to get psychotic patients out of sight and out of the way. The public needs to face the problem, not deny it—if for no other reason than economic. How many people know that over half of all the hospital beds in the country are for psychotic patients.

While we have been studying personality disorders and neuroses, the care of the totally disabled, the sickest patients, has been left to the occupational therapists, educational therapists, psychologists, social workers, hospital attendants, recreational directors and even volunteers. Our teachers failed, and perhaps we are failing, to interest the younger physicians coming into the specialty in the truly tremendous opportunities for research and rewarding work in the state (and Veterans Administration) hospitals. A British colleague was amazed to learn that in our land of plenty there are still state hospitals without a single trained psychiatrist on their staffs. Who but the physician should take the initiative in improving the conditions of state hospitals throughout the country so that positions in them will be eagerly sought instead of actively avoided. Unless we rise to the responsibility, the public may look to other groups for help they expect to get from physicians.

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